



The Evolution of NCQA Accreditation

BY CARY SENNETT, MD, PHD

NCQA's approach to accreditation has changed markedly during the past decade.

In less than 10 years, the National Committee for Quality Assurance (NCQA) has moved from its first, draft accreditation standards to a strategy for including standardized health plan performance measures in its Accreditation process. And, in less than five years, the HEDIS® (Health Plan Employer Data and Information Set) performance measures have changed dramatically as well. Originally designed to help corporate purchasers evaluate the quality of health plans, HEDIS has moved from a narrowly focused set of employer-centered measures to an expansive and increasingly complex set of measures that aims to be more consumer-centered.

Is NCQA, at this pace, in danger of outrunning its customers? No doubt, the rising bar has been a challenge to the industry. It is equally clear that NCQA requirements are creating complexity for physicians and other providers, who are facing demands for information from managed care organizations responding to NCQA's program. Does NCQA, as well, run the risk of overwhelming consumers? Is it possible that the rapid evolution of our work may leave them confused rather than enlightened? Although these issues may at first glance seem to argue in favor of slowing the pace of change, in fact what they show us is that the progress we've

made to date has accomplished exactly what we wanted it to: It has put pressure on consumers to change purchasing habits, and on health plans to work hard on quality improvement. More change is forthcoming. Quality improvement—our ultimate goal—depends on it.

The History of Accreditation

Before we can address what these issues mean for the future of accreditation, we must look at the past. NCQA became an independent organization in 1990 to promote accountability in managed care; NCQA's Accreditation program has been essential to those efforts. To date, more than half of the HMOs currently licensed in the United States have participated in NCQA Accreditation, thereby demonstrating their willingness to accept public accountability for the quality of care and service they provide.

In recent years, other organizations have begun to accredit health plans, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), long renowned for its work accrediting hospitals, and the American Accreditation HealthCare Commission/URAC, which accredits utilization management programs, PPOs, workers' compensation programs, and other health plan networks. (See January/February 1996, p. 52, and November/December 1998, p. 69.)

Today's environment is vastly different from that of 10 years ago. Prior to

NCQA's emergence onto the national scene at the beginning of the decade, quality assurance was inefficient and unsophisticated. Although several leading employers had devised crude performance measures, they did so in isolation of one another, resulting in a substantial challenge and inefficiency for health plans: how to respond to requests from multiple employers, each with different data requirements. The costs involved in responding to the redundant requests were large. Ironically, the value of the data was minimal, and the information was often useless for making plan-to-plan comparisons.

NCQA developed its Accreditation program and HEDIS measures because employers wanted assurance that they were getting quality care for the money they spent on health care premiums. As managed care was becoming more popular, there was concern about what might happen in a health care setting in which patient choice was limited to the providers in a health plan's network, and in which financial incentives tended to favor underutilization (rather than overutilization, as in fee for service). These concerns created a need for an independent and objective third-party organization to evaluate managed care systems and report its findings to the public.

Historically, NCQA Accreditation has addressed the issue of quality by assessing the key systems that underlie the delivery of care and service, including the systems health plans use to monitor care, assure

quality, and credential providers. The underlying tenet is that managed care has the potential to enhance—or threaten—the value of care delivered to a population through a set of systems that are essential to the operation of the managed care organization.

NCQA Accreditation has focused on assessing those systems through intensive expert review—both on-site and off-site—seeking evidence that those key systems are designed in a way that meets the health care service needs of the population the plans serve. As a result, NCQA accreditation has meant a health plan can document that it is doing the right things, doing them well. This documentation, in turn, offers the public evidence that a health plan is achieving the potential value a managed care system can provide.

Key Beneficiaries

The principal beneficiary of accreditation is, therefore, the health plan member. But the population may be unaware of the ben-

efit that NCQA Accreditation confers. It is the rare consumer, for example, who appreciates in any tangible way that because a health plan improved its credentialing process to meet NCQA standards, he now enjoys added protection against poor quality care. The benefit is quite real, of course, but not necessarily obvious. Even less likely is the consumer who takes comfort in the fact that her health plan has invested in a state-of-the-art information system to help it better measure and manage care.

This could be quite problematic: If the value of accreditation and HEDIS is invisible to the member, then why should a health plan make these investments? This question is particularly acute in the price-competitive markets in which health plans operate, and in an environment in which the costs of accountability are unevenly, and inappropriately, distributed—not among all entities that compete for membership, but disproportionately to HMOs and POS plans.

Fortunately, the nature of the health care market has made it possible for value to accrue to members, because so much of the purchasing decision (and the marketplace response) is driven by American corporations purchasing health benefits on behalf of employees. Employers, unlike individual consumers, have health benefits experts on staff who can better appreciate how plans that invest in the systems and processes that NCQA reviews are much more likely to deliver better care and service. Thus, even if consumers don't appreciate the value of sophisticated information systems or thorough credentialing processes, they still realize a substantial benefit because the care and service they receive is, in part, defined by these improved systems.

Benefits also accrue to noncommercial health plan members, such as Medicare members in a plan that uses common quality improvement systems to support commercial and Medicare products. And some benefits may extend into the community as, for example, physicians begin to improve the care they deliver to their fee-for-service patients. Anecdotal data suggest this is happening, and it is not hard to imagine why: A doctor working in both an HMO and on a fee-for-service basis is likely to apply new, improved treatment practices promoted by the HMO to all his or her patients, not just to HMO members.

Accreditation obviously offers a substantial marketplace benefit to health plans as well, just as we intended. There are other significant benefits, although they often go unrecognized. To illustrate: Imagine a world in which there were no NCQA Accreditation; how, in that world, would the demand for quality assurance be met?

First, one might see a return to profoundly redundant corporate efforts to evaluate managed care contractors. Or, one might see more extensive state and federal oversight. More than a dozen states accept NCQA Accreditation as satisfying certain requirements for licensure; if there were no

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NCQA Accreditation, states' requirements would probably be more cumbersome. Thus, part of the value of accreditation is the efficiency that comes of having a private-sector locus for evaluation.

Health plan administrators who have undergone the process of meeting NCQA's standards say it has helped them understand and improve their business processes. NCQA surveyors note obvious pride on the part of health plan staff who, during the course of the survey, describe the work they have accomplished. This intrinsic value may be intangible, or at least more difficult to measure, but NCQA believes that it is real, for we hear it over and over again.

Addressing the Challenges

Along with these benefits come many challenges associated with accreditation. Not the least of these is financial.

The average cost of undergoing an NCQA Accreditation survey is about \$40,000—a significant sum for even well established health plans. (NCQA offers a less expensive New Health Plan Accreditation for plans less than two years old that may still be trying to find their financial footing.) The challenges are that much more acute for plans lacking the sophisticated information systems necessary to make data collection an efficient process. To satisfy NCQA Accreditation requirements, health plans (and health plan providers) that rely on paper-based record-keeping systems may need to conduct medical record reviews, a laborious and expensive process when done by hand, but short work when done electronically.

Another challenge is avoiding "information overload." Because quality measures are evolving so rapidly, some observers are concerned consumers may not have enough time to digest the information they receive from their health plans, employers, and the media before the measures are revised.

Recognizing this concern, NCQA strives to ensure that its work is relevant

and useful to the audiences it serves. In addition to large corporate purchasers, a variety of constituencies have helped shape the evolution of NCQA's work. The interests and concerns of employers, consumers, providers, policy makers, and, in particular, health plans have been represented on NCQA's Board of Directors and other key committees since the organization's inception.

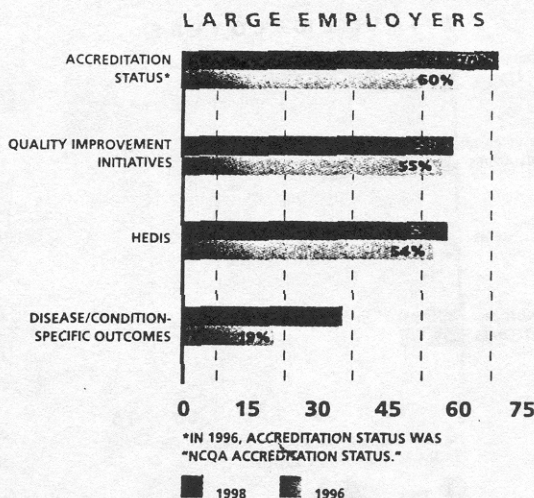
More recently, NCQA has established four key advisory panels, one each to represent consumers, practicing physicians, purchasers, and other health care providers. These panels meet several times per year and provide invaluable input to NCQA on how to make our various programs and activities more useful and relevant to their respective constituencies.

In the months and years ahead, NCQA's Consumer Advisory Council will help us to fine tune our information products so that more and more consumers become aware of and use them to guide their selection of a health plan.

Our experience suggests that purchasers and consumers do not feel overwhelmed by information. In fact, NCQA believes enthusiasm for accreditation—and for HEDIS—is at an all-time high. Every year, more and more corporations require health plans to participate. Although various studies have reached different conclusions, at least 30 percent of Fortune 100 employers mandate NCQA Accreditation of the health plans with which they do business, and many more companies request it. Even more employers require HEDIS data, as does the Health Care Financing Administration (HCFA) for Medicare contractors.

Every year, we see more and more report cards in the media, and—judging

Do you use the following measures to evaluate health care plans?



Source: Watson Wyatt Worldwide/Washington Business Group on Health.

from the response of publications such as *U.S. News and World Report* and *Newsweek*—the consumer appetite for quality information appears not nearly sated. Rather, sophisticated consumers are more than ever concerned about quality managed care, and they continue to pressure NCQA to move our work full speed ahead.

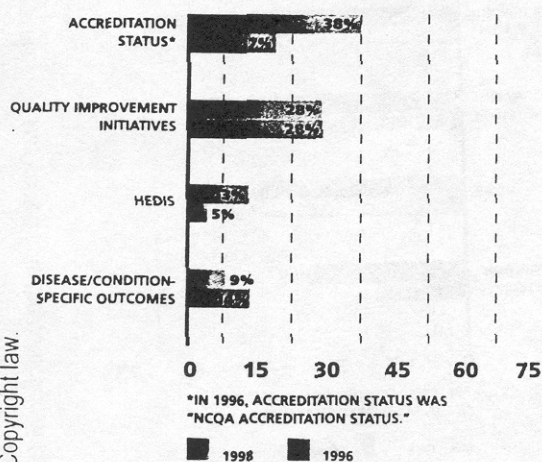
The Next Generation: Accreditation '99

NCQA's new Accreditation '99, which will become the standard over the next two years, is designed to give the public far better information than was previously available. The most important aspect of Accreditation '99 is that "results count"—the accreditation outcome will no longer be a comment only on the quality of systems design and systems operation.

Beginning in July, a health plan accreditation result will depend not only on the integrity of the systems that NCQA historically has assessed (such as quality assurance and provider credentialing), but also on selected results as demonstrated through the reporting of audited HEDIS statistics. Systems assessment will continue to be important—in fact, it will count for 75 percent of the overall score when the program begins. But HEDIS results—both

Do you use the following measures to evaluate health care plans?

SMALL EMPLOYERS



Source: Watson Wyatt Worldwide/Washington Business Group on Health.

effectiveness of care and satisfaction—will count as well and, over time, will likely contribute proportionately more.

The measures included in Accreditation '99 are, by design, intuitively understandable and widely reported. Using widely reported measures, such as childhood immunization rates, mammography rates, and overall member satisfaction, ensures that NCQA will have sufficient data on hand to calculate meaningful national and regional averages and percentiles to which plan results will be compared. Using intuitively understandable measures, such as those mentioned above, reinforces for consumers and others the importance of using accreditation information to help guide health plan selection decisions. In the future, additional HEDIS measures will likely be included in NCQA's Accreditation program as well.

The way NCQA communicates with those who use accreditation information is also changing markedly. Recognizing that experts think of quality differently from the way that purchasers and consumers do, NCQA reports will no longer talk about a plan's "Quality Management," "Utilization Management," or "Provider Credentialing" systems. Instead, building on the work of the Foundation for Accountability (FACCT), NCQA will describe the plan's

success at assuring "Access and Service" and "Qualified Providers," and comment on how well the health plan succeeds at assisting members in "Staying Healthy," "Getting Better," and "Living with (chronic) Illness." NCQA commissioned FACCT to conduct consumer research to help develop these new categories. Our work with FACCT suggests that these terms are far more meaningful to consumers and will make accreditation more understandable (and therefore more useful) for them.

NCQA is also changing the names of the accreditation results categories—again to make them more intuitive for consumers, but also to assure the distinction among plans that has slowly been lost. As more and more health plans have responded to NCQA Accreditation, there has been a steady improvement in overall health plan results. On the one hand, this is good news—it means the industry has demonstrated, overall, that it is better prepared to meet the needs of members. On the other hand, this "shift to the right" means it is no longer possible to distinguish between plans that are the "best of the best" and those that are strong in some areas but still developing in others. As a result, NCQA has introduced a new accreditation category—Excellent—reserved for those plans (expected to be less than 10 percent) that demonstrate not only high quality systems, but consistently superior performance across a broad range of measures.

Finally, NCQA has changed the periodicity of the accreditation review, again to respond to purchaser and consumer concerns. With the bulk of plans receiving full (three-year) accreditation, most plans have been reviewed only once every three years. Given the dynamism in the marketplace, this seems a very long time.

The incorporation of annual HEDIS data, however, creates a straightforward opportunity for NCQA to keep accreditation decisions more current. Under Accreditation '99, a plan's status level may change annually based on HEDIS results. Actual on-site surveys, however, will be no more frequent—every three years for plans that achieve an "Excellent" or "Commendable" rating, and every year for plans that do not.

The Longer Term Future of Accreditation

It may be premature to discuss the future of accreditation beyond Accreditation '99, because it is important to observe how organizations respond to these changes before moving much further. Even so, there are some elements of the future one can safely divine:

- First, accreditation must address quality in settings other than HMOs. Informed choice cannot exist until purchasers and consumers have more information about PPOs, PSOs, and fee-for-service plans as well. The challenges here are not insignificant; many of these organizations lack the systems and processes—quality improvement, credentialing, preventive health—that are the core of NCQA's current Accreditation program. But the need is compelling.

- Second, accreditation must begin to assess care closer to the "point of service." That is, we need to begin to look at the providers that make up a health plan delivery system. While the managed care organization plays a critical role in determining the quality of health care, the providers that comprise its networks are equally important. And it is about these providers—from hospitals to medical groups to individual physicians—that consumers now want to know. For NCQA, this begins with the evaluation of organized provider groups—"physician organizations." Where it will take us after that is hard to know, although NCQA has

no current plans to accredit or certify individual providers, territory that is already covered by the nascent American Medical Accreditation Program.

•Finally, accrediting organizations will have to work together, to assure that our work is coherent and not duplicative in the minds of consumers. There are too few resources for anyone to tolerate redundancy and too great a risk that different performance measures coming from multiple accrediting organizations will confuse consumers.

We are already seeing the beginning of this future: NCQA, the Joint Commission, and the American Medical Accreditation Program have organized a Performance Measurement Coordinating Council to assure that our measurement efforts are synergistic. In fact, we expect that later this year overlapping measure development efforts will actually merge, yielding more broadly applicable measures and a more coherent, efficient quality measurement system. Initially, the effort will focus on developing common criteria and processes for creating new measures. In the future, the three organizations plan to merge expert panels in selected areas, such as cancer care.

The future should bring further collaboration among these organizations, as accreditors attempt to respond to public concerns about quality throughout the health care system by giving consumers the information they want and need. ■

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Information about Accreditation '99 is available on the NCQA web site, www.ncqa.org. The standards themselves may be obtained through the NCQA publications department.



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